Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012753	A. BUILDING: _____ B. WING _____	R 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA HOMEHEALTH CARE LLC	6350 WESTHAVEN DRIVE SUITE E INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments This visit was a follow up to the initial home health state licensure survey conducted on July 16 and 17, 2012. Survey Date: September 4, 2012 Facility #: 012753 Medicaid Vendor #: N/A Surveyors: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor, Team Leader David Moran, BSN, RN, Public Health Nurse Surveyor During this survey, eleven deficiencies were corrected. Quality Review: Linda Dubak, R.N. 08/05/2012	{N 000}		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE